

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

FABRAZYME (agalsidase beta)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext. and options _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

Diagnosis _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY**

CRITERIA:

- ▶ Documented deficient plasma or leukocyte a-galactosidase A (a-gal) - OR
- ▶ Documented a-gal deficiency and / or mutation in the a-gal A gene in heterozygous females.
- ▶ Covered only for patients with documented ADA deficiency

AUTHORIZATION:

6 Months

RE-AUTHORIZATION:

Re-authorization by request of physician or pharmacy with a telephone call.

